FAX COVER SHEET ONLY TO BE USED FOR VHAP Z9 COVERAGE FOR INMATES BEING TRANSFERRED TO THE ER

Date: _____

Inmates name: _____

Inmates DOB: _____

Inmates SSN: _____

Inmates Facility: _____

Date transferred to ER: _____

Name of Hospital: _____

Name of Caseworker: _____

Phone number of caseworker: _____

PLEASE FAX THIS COMPLETED FORM ALONG WITH A SIGNED AND COMPLETED VHAP APPLICATION TO THE ADPC AT 802-871-3239.

If you have any questions on this form please email cindy.chaffee@state.vt.us